STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

2. Exceptional Care - Hospital Residing (category of service 38). Reimbursement is available for hospitals providing hospital residing long term care when the level of care is not routinely performed within a skilled setting, such as ventilator care, and the patient cannot be placed in a skilled nursing facility because the level of care is not available. Exceptional care is defined by the Department as the level of care required by persons who are medically stable and ready for discharge from a hospital but who require a multi-disciplinary level of care for physician, nurse, and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be a medical necessity. This includes, but is not limited to, persons with acquired immune deficiency syndrome (AIDS) or a related condition, head injured persons, and ventilator dependent persons. Reimbursement for this type of care is at the average statewide rate for exceptional care. For a hospital to be eligible for such reimbursement, the following criteria must be met:

   a. The hospital must document its attempt to place the patient in at least five appropriate facilities.

   b. Documentation (form DPA 3127) must be attached to the appropriate claim form and submitted to the Department.

   c. Reimbursement is limited to services provided after the minimum number of contacts have been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement will be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.

3. DD/MI Non-Acute Care - Hospital Residing (category of service 39). Reimbursement is available for hospitals providing hospital residing long term care when the pre-admission screening agent has not completed the assessment, planning or discharge process. Reimbursement for this type of care is at the average statewide DD/MI rate. For a hospital to be eligible for such reimbursement, the following criteria must be met:

   a. The hospital must document that the pre-admission screening agent has not completed the assessment, planning or discharge process.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

b. Reimbursement is limited to a maximum of three non-acute level of care days. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

XII. Alternatives

All provisions of Chapters I. through XII. of this Plan shall be in effect during the fiscal year for so long as the Director of the Department finds that:

09/91 A. The total number of hospitals agreeing to be reimbursed pursuant to the provisions of this state plan is sufficient to assure that medical assistance recipients have reasonable access to hospital services. In making this determination, factors considered by the Department include but are not limited to service availability and the number of recipients within a geographic area, recipient travel time to obtain services, and availability of a range of services within a geographic area.

09/91 B. The provisions are approved by the Department of Health and Human Services through the approval of this State Title XIX Plan.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

XIII. County-Owned Hospitals in a County with a Population of Over 3 Million

==07/95 A. Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three Million.

10/92 In accordance with Section C.8. of Chapter II., county-owned hospitals in an Illinois county with a population greater than three million are excluded from the DRG PPS and are reimbursed in accordance with this Section.

07/91 B. Base Year Costs

10/93 1. The hospitals' base year operating costs shall be contained in the hospitals' audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospitals' fiscal years ending between 20 and 31 months prior to the fiscal year for which rates are being set.

10/93 2. The hospitals' base year capital related costs shall be derived from the same audited cost reports used for operating costs in Section B.1. above.

10/93 3. The hospitals' base year direct medical education costs shall be derived from the same audited cost reports used for operating costs in Section B.1. above.

10/93 4. The base year cost per diem shall be the sum of the operating cost per diem, capital related cost per diem and medical education cost per diem defined in Sections B.1. through B.3. above.

10/93 5. New hospitals, for which a base year cost report is not on file, will be reimbursed the per diem rate calculated in Section B.4. above and inflated in Section D.1. below.

10/93 C. Restructuring Adjustment. Adjustments to the base year cost per diem, as described in Section B.4. above, will be made to reflect restructuring since filing the base year cost reports. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost reports to determine restructuring costs. If audited cost reports become available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports

received at the Office of Health Finance, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Office of Health Finance between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the reports are received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of the national total hospital market basket price proxies, (DRI), and added to the base year cost per diem, as described in Section B.4. above, which is subject to the inflation adjustment described in Section D. below.

07/92 D. Inflation Adjustment For Base Year Cost Report Inflator

10/93 1. The base year cost per diem, as defined in Section B.4. above, shall be inflated from the midpoint of the hospitals' base year to the midpoint of the time period for which rates are being set (rate period) according to the historical rate of annual cost increases. The historical rate of annual cost increases shall be calculated by dividing the operating cost per diem as defined in Section B.1. above by the previous year's operating cost per diem.

10/93 2. Effective October 1, 1992, the final reimbursement rate shall be no less than the reimbursement rate in effect on June 1, 1992; except that this minimum shall be adjusted each July 1 thereafter by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports.

07/91 E. Review Procedure

The review procedure shall be in accordance with Chapter IX.

07/95 F. Applicable Inpatient Adjustments

07/95 1. The criteria and methodology for making applicable DSH adjustments to hospitals which are exempt from the DRG PPS as described in Section C.8. of Chapter II., shall be in accordance with Section C.7.a. of Chapter VI.

07/95 2. The criteria and methodology for making applicable Medicaid Percentage Adjustments to hospitals which are exempt from the DRG PPS as described in Section C.8. of Chapter II., is described below.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

07/95 a. The payment adjustment shall be $150 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate as described in Section C.7.e. of Chapter VI, exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate as defined in Section C.7.c. of Chapter VI multiplied by 3.75. This payment adjustment is based on a rate year 1993 base rate and shall be trended forward to the current rate year for inflationary increases.

07/95 b. The amount calculated pursuant to Section F.2.a. above shall be adjusted on October 1, 1995, and annually thereafter, by a percentage equal to the lesser of:

07/95 i. The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

07/95 ii. The percentage increase in the statewide average hospital payment rate, as described in Section C.8.h. of Chapter VI, over the previous year's statewide average hospital payment rate.

07/95 c. The amount calculated pursuant to Sections F.2.a. through F.2.b. above shall be no less than the rate calculated in accordance with Section C.7.b. of Chapter VI in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

07/95 d. The amount calculated pursuant to Section F.2. of this Chapter, shall be the Medicaid percentage adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

07/96 3. ~~Critical/Inpatient~~County Provider Adjustment.

a. Effective July 1, 1995, hospitals reimbursed under this Chapter shall be eligible to receive a ~~critical/inpatient~~county provider adjustment. The methodology used to determine the add-on payment amount is as follows:

07/96 i. ~~For the rate year~~Beginning with July 1, 1995, ~~through June 30, 1996~~ hospitals under this Chapter shall receive $15,500 per Medicaid inpatient admission in the base period.

TN # 96-13 APPROVAL DATE APR 2 8 1997 EFFECTIVE DATE 07-1-96

SUPERCEDES
TN # 95-22

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

07/95 ii. The payments made under this subsection shall be made on a quarterly basis.

==07/96 b. ~~Critical/Inpatient~~County Provider Adjustment Definitions

07/96 i. "Base Period" means State fiscal year 1994./~~for/critical inpatient/adjustments/calculated/and/paid/during/State fiscal/year/1996/~~

07/96 ii. "Medicaid Inpatient Admission" means hospital inpatient admissions provided in the base period, which were subsequently adjudicated by the Department through the last day of June, 1995, ~~preceding/the/rate/year/and/contained within/the/Department's/paid/claims/data/base/~~ for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns and Medicare/Medicaid crossover days.

07/95 4. Hospitals reimbursed under this Chapter shall receive supplemental inpatient payments. Effective with admissions on or after July 1, 1995, supplemental inpatient payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in Section B.4. above, as adjusted for restructuring, as described in Section C. above, and as adjusted for inflation, as described in Section D. above, and the calculated Medicaid percentage per diem payment adjustment, as described in Section F.2. of this Chapter, by the hospital's percentage of inpatient charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. Effective July 1, 1995, the supplemental inpatient payments calculated under this subsection shall be no less than the supplemental inpatient rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days. The supplemental inpatient payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.

07/91 G. Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section F. of Chapter VIII.

10/92 H. Trauma Center Adjustments. Trauma center adjustments shall be made in accordance with Section E. of Chapter VI.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

10/92 I. Reductions to Total Payments

1. Copayments

Copayments are assessed under all medical programs administered by the Department and shall be assessed in accordance with Section E.1. of Chapter VII.

2. Third Party Payments

The requirements of Section E.2. of Chapter VII. shall apply.

10/92 J. Prepayment and Utilization Review

Prepayment and utilization review requirements shall be in accordance with Section L. of Chapter VIII.

10/92 K. Cost Reporting Requirements

Cost reporting requirements shall be in accordance with Section G. of Chapter VIII.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

XIV. Hospitals Organized Under the University of Illinois Hospital Act

10/93 A. Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act

In accordance with Section C.8. of Chapter II., hospitals organized under the University of Illinois Hospital Act shall be excluded from the DRG PPS and shall be reimbursed in accordance with this Section.

09/91 B. Base Year Costs

07/95 1. Each hospital's base year cost per diem shall be derived from an audited cost report (see 42 CFR 447.260 and 447.265 (1982) for hospitals' fiscal year 1992.

2. For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.

10/92 C. Restructuring Adjustment

Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Office of Health Finance, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Office of Health Finance between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the report is received.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of the national total hospital market basket price proxies, (DRI), and added to the base year costs.

10/93 D. Inflation Adjustment For Base Year Cost Report Inflator

Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set according to the hospital's historical rate of annual cost increases.

09/91 E. Review Procedure

The review procedure shall be in accordance with Chapter IX.

10/93 F. Applicable adjustments for DSH Hospitals.

10/93 1. The criteria and methodology for making applicable adjustments to DSH hospitals which are exempt from the DRG PPS as described in Chapter II., shall be in accordance with Section C.7. of Chapter VI.

07/95 2. Effective October 1, 1993, in addition to the DSH payment adjustments described in Section C.7. of Chapter VI., hospitals reimbursed under this Chapter shall receive supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Chapter shall be calculated by multiplying the sum of the hospital's base year costs, as described in Section B. above, as adjusted for restructuring, as described in Section C. above, and as adjusted for inflation, as described in Section D. above, and the calculated disproportionate share per diem payment adjustment as described in Section C.7. of Chapter VI., by the hospitals' percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. The resulting product shall be multiplied by 4.50, and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

09/91 G. Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section F. of Chapter VIII.